



CLINICAL SKILLS CHECKLIST *Pharmacist*

Please list any limitations or comments you may have on a separate sheet

IDENTIFYING INFORMATION	Last Name	First name	Middle name	Previous Surname		
CERTIFICATIONS	<input type="checkbox"/> BLS expiration date: _____ <input type="checkbox"/> ACLS expiration date: _____ <input type="checkbox"/> Other: expiration date: _____					
LICENSES/ CERTIFICATIONS <small>List all states in which you are or have ever been licensed and/or certified, beginning with your original state license</small>	Original State License/Certificate	License/Certificate #	Expiration Date	State License/Certificate	License/Certificate #	Expiration Date
	State License/Certificate	License/Certificate #	Expiration Date	State License/Certificate	License/Certificate #	Expiration Date
	Please list other certifications, licenses, permits, registrations, etc. (including inactive)					
DISPENSE CONTROLLED SUBSTANCE PERMIT	Permit Number			Expiration Date		
	Permit Number			Expiration Date		
AREAS OF INTEREST	<input type="checkbox"/> Hospital-based <input type="checkbox"/> Retail <input type="checkbox"/> Treatment oriented practice <input type="checkbox"/> Other healthcare facilities: _____					
CLINICAL EXPERIENCE	<i>Please rate your skills in the areas below using the following values: 1 = No experience 2 = Some experience (less than 1 yr.) 3 = Experienced (At least 1 yr.) 4 = Highly experienced (2 yrs. or more)</i>					
	Medication Classifications	1	2	3	4	Computer-based <i>continued</i>
Analgesics – Non-narcotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DEA website access	<input type="checkbox"/>
Narcotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Electronic medication systems :	<input type="checkbox"/>
Antibiotics/Anti-Infectives – Topical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADSX	<input type="checkbox"/>
Systemic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CareManagement	<input type="checkbox"/>
Antineoplastics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cerner	<input type="checkbox"/>
Cardiovascular Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CPSI	<input type="checkbox"/>
Antiarrhythmics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epic	<input type="checkbox"/>
Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBOC	<input type="checkbox"/>
Antihypertensives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meditech	<input type="checkbox"/>
Antilipidemics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nexgen	<input type="checkbox"/>
Endocrine/Metabolic Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PDX	<input type="checkbox"/>
Gastrointestinal Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RX3000	<input type="checkbox"/>
Pulmonary/Respiratory Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>
CNS Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication dispensing systems:	<input type="checkbox"/>
Psychotherapeutic Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abbott	<input type="checkbox"/>
					Accudose	<input type="checkbox"/>
Medication Preparation	1	2	3	4	Baxter	<input type="checkbox"/>
IV Admixture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	McKesson	<input type="checkbox"/>
Compounding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pyxis	<input type="checkbox"/>
TPN preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>
					Third-party billing	<input type="checkbox"/>
Computer-based	1	2	3	4	Patient education	<input type="checkbox"/>
Calculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Veterinary prescriptions	<input type="checkbox"/>
Drug interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Average number of prescriptions filled per day? _____						
Additional Clinical Skills: _____						
Comments (if indicated): _____						

I affirm that all information given on this page is true and accurate.

Initials _____ Date _____